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November 2, 2017

Ex Parte

Ms. Marlene H. Dortch
Secretary
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

Re: *Rural Health Care Support Mechanism*, WC Docket No. 02-60

Dear Ms. Dortch:

On October 31, 2017, Chris Nierman of General Communication, Inc. ("GCI") and I met with Jay Schwarz, Legal Advisor to Chairman Pai. We discussed the need for a stable, long-term solution to budgetary issues surrounding the Rural Healthcare support mechanism. For Rural Healthcare Providers (HCPs) in extremely high cost areas, pro-rata reductions to meet the budgetary cap have created substantial and unmanageable uncertainty with respect to the amount that the HCPs will themselves have to pay for critical telecommunications services. For remote Alaska, this is especially true because remote Alaska HCPs are funded through the federal Indian Health Service operated by the U.S. Department of Health and Human Services, which provides little opportunity to address significant mid-year cost changes. For FY2016, the Commission on a one-time basis allowed service providers serving HCPs in remote Alaska to reduce their charges by the amount of the pro-rated reduction. However, this is not a sustainable solution, and if not held to a one-time solution would have undesirable impacts on the competitive bidding process, lead to a reduction in fiscal discipline on HCPs, and hinder the ability of service providers to make private investments to deploy communications facilities in remote areas.

While GCI believes that the best way to address the current issues with the Rural Healthcare budget would be to increase the cap to reflect inflation since 1997, we recognize that other measures may also be necessary. Accordingly, we propose the attached plan that would create priority for payment of commitments to "Highly Rural" HCPs, while at the same time increasing the minimum payment required for Highly Rural HCPs in the Telecommunications Program. This balances supporting Congress's express statutory goal of defraying the costs of telecommunications from HCPs in more remote communities to urban centers with ensuring that those same HCPs have a sufficient economic incentive to procure what they reasonably need at the most reasonable prices available.

To define "Highly Rural", GCI proposes using the same test as the Veterans Administration for its program that supports travel costs for veterans needing treatment. Both programs serve similar purposes—providing access to health care for individuals in very remote locations.

To increase the minimum payment by HCPs in the Telecommunications Program, this proposal would start with a minimum payment of 1% of the rural rate, and increase that by 1%

each year until it reaches 5% in the fifth year. If, along the way, the Commission were to determine that further co-payment increases are not necessary to achieve fiscal discipline, it could suspend the further increases in the minimum co-payment.

We also proposed an interim burden sharing mechanism with respect to any pro-rata reductions in remote Alaska during FY2017. This mechanism is designed to start increasing co-payments, while at the same time recognizing that there are committed but not disbursed funds from remote Alaska, as well as other reserves that could more equitably split the pro-rata burden between HCPs, service providers, and the USF.

Please contact me if you have any questions regarding this matter.

Sincerely,

John T. Nakahata
Counsel to General Communication, Inc.

cc: Jay Schwarz
Trent Harkrader
Ryan Palmer

Attachment

A LONG TERM PLAN FOR STABILIZING RURAL HEALTHCARE SUPPORT WITHIN BUDGET: PRIORITY FOR "HIGHLY RURAL" COUNTIES STARTING IN FY2018

PROBLEM

In FY2016, for the first time, USAC commitments would have exceeded the $400 million annual cap on the Rural Healthcare (RHC) universal service support mechanism. This resulted in across the board reductions for all RHC recipients of 7.5%, no matter how rural the healthcare provider. For remote entities with supported high connectivity costs, this resulted in large increases in the costs to be paid by the rural healthcare provider (HCP). Neither HCPs nor their communications providers can plan for these increased charges. With continued growth in both the Telecommunications Program and the Healthcare Connect Fund (HCF), this situation is likely to recur in future years.

PROPOSED FUTURE REFORM: FY2018-FY2022

This proposal combines priority for support for "Highly Rural" HCPs with phased-in, increased financial contribution from Highly Rural HCPs under the Telecommunications Program.

- Establish "Highly Rural Priority" for both Telecommunications Program and HCF, whereby eligible HCPs located in Highly Rural counties receive priority funding, similar to Category One in the E-Rate program. These Highly Rural HCPs would have their commitments drawn first from the RHC program budget, before non-Highly Rural HCPs.
    - The U.S. Department of Veteran's Affairs has a "Highly Rural" classification for transportation grants to VA medical services, which we propose as the basis for establishing a funding priority in RHC. The definition is any county or borough (or census area that is not in an organized county or borough) "having a population of less than seven persons per square mile." In Alaska, the consolidated city-boroughs of Anchorage and Juneau and the Fairbanks North Star borough would not be "Highly Rural"; the remainder of the state would be.
    - Preliminary analysis from The Brattle Group suggests that nationwide approximately $131M was committed to Highly Rural areas in FY2016.

- Bring greater fiscal discipline to the Telecommunications Program so that Highly Rural priority will not unduly restrict support outside of Highly Rural communities. Highly Rural HCPs would pay a minimum amount that increases each year over 5 years. For FY2018, the minimum Highly Rural HCP payment would be the higher of the urban rate or 1% of the rural rate. In FY2019 through FY2022, the minimum amount would increase by 1% per year until reaching a 5% copayment (i.e. 2% in FY 2019; 3% in FY2020; 4% in FY2021; 5% in FY2022).
    - Phased-in increased contributions for Highly Rural HCPs in Telecom Program addresses concerns about sufficient "skin in the game" to hold down costs.
    - HCF HCPs continue to pay 35%. This share does not change, whether or not Highly Rural.
    - A "circuit breaker" mechanism to suspend increases in minimum payments if the cap is not exceeded should be included so that Telecommunications Program HCPs are not unduly constrained in obtaining needed services.

- Consortia that combine Highly Rural and non-Highly Rural HCPs do not get Highly Rural priority because of administrative burdens and problems of allocation, but individual HCPs in Highly Rural areas can instead choose to apply separately for the Highly Rural priority.

COMPATIBILITY WITH OTHER POTENTIAL LONG TERM SOLUTIONS

This long term priority solution can work at any budget level. It does not preclude increasing the RHC Program budget to reflect the fact that this budget cap has not increased since it was set twenty years ago.

Similarly, this solution can also work in tandem with other ways of applying budgetary constraints to RHCs that do not qualify as "Highly Rural." For example, this proposal works with both a pro rata reduction and a potential elimination of a uniform number of dollars per supported entity (similar to the way the High Cost Loop Support mechanism worked to stay within its nationwide cap in the High Cost USF program).

PROPOSED FY2017 INTERIM SHARED BURDEN WAIVER

For FY2016, the FCC granted a one-time waiver to permit Remote Alaska service providers to reduce the price charged to Remote Alaska HCPs by the amount of the pro-rata reduction in commitments due to the RHC program budget cap. This removed immediate budgetary pressure on the Alaska HCPs, but imposed the entire burden of the RHC program budget cap on their service providers. If repeated while considering a transition to a longer-term solution, this would stunt private investment and infrastructure deployment by service providers and reduce price discipline on Alaska HCPs.

For FY2017, assuming that commitments would otherwise exceed the budget cap, a better approach would be to split the burden in Remote Alaska between the HCP, its service provider, and the USF as follows:

- USAC covers 50% of any pro rata reduction in Remote Alaska, drawing from USF reserves, projected previously committed but undisbursed RHC funds up through and including FY2017.
- Remote Alaska Service Providers be permitted to forgive up to 25% of any pro rata reduction without being treated as a repricing of the service for support calculation purposes.
- Remote Alaska HCPs cover the remaining 25% of any pro rata reduction, providing some incentive to restrain, where possible, supported services purchased in the remainder of FY2017.

In order to influence HCP purchases during the remainder of FY2017, it would be important to put this structure in place as soon as practical.